ARTICLE 4

SECTION 16

INTER/INTRA PROGRAM TRANSFER

1. GENERAL

A person or family discontinued from cash-based Medi-Cal (except SSI/SSP) is entitled to evaluation for Medi-Cal Only benefits without having to make a new application. This section provides instructions for processing inter/intra program transfers for persons who lose eligibility to cash-based Medi-Cal resulting from a discontinuance of CalWORKs, RCA/CHEP or IHSS. Ramos vs. Myers procedures for persons discontinued from SSI/SSP are also included in this section. MEM 50183

2. DEFINITIONS

A. Intra-program Transfer

An intra-program transfer occurs when a person's or family's eligibility status changes from one aid category to another aid category and the first digit of the aid code remains the same. Example: 30 to 37.

B. Inter-program Transfer

An inter-program transfer occurs when a person's or family's eligibility status changes from one aid category to another aid category and the first digit of the aid code changes. Example: 30 to 64.

3. INTER/INTRA PROGRAM REFERRAL PROCEDURES

A. RCA/CHEP Referrals

Persons discontinued from RCA/CHEP (aid types 01 and 08) will be referred to Medi-Cal Only eligibility by the cash worker upon request of the beneficiary. The beneficiary must request continuing within five calendar days from receipt of the RCA/CHEP discontinuance NOA. The RCA/CHEP worker will attach a gram to the case requesting an intra/inter program transfer determination and forward the case to the RCA/CHEP supervisor. The RCA/CHEP supervisor will hand carry the case to the intake scheduling supervisor.

1) Intake Scheduling Supervisor Responsibilities

Within two days from receipt of the inter/intra program transfer referral the intake scheduling supervisor will:

a) Review the appropriateness of the referral. If the beneficiary was discontinued for one of the reasons listed in C. below, the referral is not

appropriate. Cases that are not eligible for an automatic inter/intra program transfer will be returned to the RCA/CHEP supervisor. The intake scheduling supervisor will notate the reason for the rejection on the referring gram; or

b) Log in an appropriate referral on the inter/intra program transfer log; and

c) Assign the case to an intake worker, or inter/intra program transfer worker, in accordance with district policy.

2) Intake Worker Responsibilities

Upon receipt of the inter/intra program transfer request, the intake worker will:

a) Photocopy the necessary documents/verifications needed to establish the Medi-Cal case; and

b) If there is sufficient information in the RCA/CHEP case to make an eligibility determination, grant the case using the appropriate transfer codes. The RCA/CHEP renewal date will determine the next Medi-Cal redetermination date; or

c) If there is insufficient information in the RCA/CHEP case to make an eligibility determination, open pend the case and generate automated letter 971, to be completed by the worker. If the beneficiary doesn't respond within ten days, the case may be denied. The worker will use NOA Code 943 to generate a denial of the inter/intra program transfer because of failure to provide information needed to make a Medi-Cal eligibility determination. Forward the closed RCA/CHEP case to Records Library.

B. Inter/Intra Program Transfer Not Required

Beneficiaries are not to be referred for an inter/intra program transfer determination when the RCA/CHEP case has been discontinued for any of the following reasons:

1) Loss of California residence;

2) A move with loss of contact and County mail sent to the beneficiary has been returned;

3) Death;

4) Intercounty transfer;

5) Failure to provide information necessary to meet RCA/CHEP requirements, and these same requirements exist for all Medi-Cal only programs for which the person may be eligible;

6) Failure to complete the renewal process.

C. Eligibility Requirements, RCA/CHEP Referrals

The beneficiary is not required to complete an application form SAWS1 to be granted an inter/intra program transfer. A new SOF will not be requested if the existing SOF is less than a year old. ACWDL 03-29

The RCA/CHEP renewal date will determine the next Medi-Cal redetermination date. If the RCA/CHEP renewal is due in the month of or month following the inter/intra program request, the worker will complete the Medi-Cal renewal following the procedures in the MPG Article 4, Section 15.

If the worker determines that the beneficiary will have a share of cost, this is not considered an adverse action and is not subject to the ten-day notice requirement.

4. CalWORKs DISCONTINUANCES ACWDL 01-36

SB 87 mandates continued Section 1931(b) Medi-Cal-Only eligibility for discontinued CalWORKs beneficiaries except in circumstances that indicate Medi-Cal ineligibility (e.g., death, out-of-state residency). When CalWORKs is approved, Medi-Cal eligibility under Section 1931(b) is also approved. However, a discontinuance of CalWORKs benefits does not necessarily constitute automatic discontinuance from the Section 1931(b) Medi-Cal Program. Unless there is clear evidence that eligibility for ongoing Medi-Cal benefits is lost, discontinued CalWORKs recipients must continue to receive Medi-Cal benefits under Section 1931(b) or be evaluated for other Medi-Cal programs (see 4.A. below). CalWORKs discontinued cases will be converted to Aid Code 38 (AC 38), but must then be converted to Section 1931(b) or other ongoing Medi-Cal if eligible. See Appendix 4-16-E for automation grid for AC 38 cases that transfer to 1931(b).

A. CalWORKs Discontinuance Reasons that Do Not Affect Section 1931 (b) Eligibility

CalWORKs persons who are discontinued for reasons that do not affect Section 1931(b) eligibility shall continue to receive Section 1931(b) benefits without the worker having to complete an eligibility determination. Discontinuance reasons that do not affect Section 1931(b) include, but are not limited to: ACWDL 01-36

- non-cooperation with Welfare-to-Work;
- termination due to the 60-month time limit for receipt of CalWORKs benefits;
- failure to provide a CalWORKs income report (this does not include instances when a change is reported that affects Medi-Cal eligibility, but required verification is not provided);
- immunization requirement;
- school attendance;
- fleeing felons;
- drug felons;
- intentional program violator; or
- non-cooperation with statewide Fingerprinting Imaging System.

When benefits are discontinued for one of the above reasons, an AC 38 case must be opened without a new evaluation for ongoing Medi-Cal eligibility. The statement of facts and other pertinent forms and documentation from the CalWORKs case record must be copied and filed in the Medi-Cal case record and Section 1931(b) benefits granted. The redetermination date for the Section 1931(b)-only case remains unchanged from the CalWORKs renewal date.

Note: Although persons discontinued for the reasons stated above are converted to the AC 38, no evaluation for Medi-Cal is required. This rule assumes that the CalWORKs case record was properly documented. If not, the worker must follow up by obtaining the required documentation. However, CalWORKs cases that close for a reason that may affect Medi-Cal eligibility are subject to an *ex parte* review. See Appendix B for a chart to assist workers in determining when an *ex parte* review is required.

B. *Ex-Parte* Review Required for Certain CalWORKs Discontinuances

CalWORKs cases that close for a reason that may affect Medi-Cal eligibility are subject to an *ex parte* review as described in MPG Article 4, Section 7, Item 9.B. This includes a parent in a two-parent CalWORKs family, who leaves the home.

C. CalWORKs Denials (Rollovers) and Diversion Cases

All CalWORKs denials (including failure to provide) must be evaluated for Medi-Cal eligibility. Workers are to use the *ex parte* process as required as part of this evaluation. The SAWS2 CalWORKs statement of facts must be used as the Medi-Cal statement of facts. The original or a copy must be filed in the Medi-Cal case record. An original signature is not required.

D. Foster Care

Foster care cases transitioning into Section 1931(b) Medi-Cal are treated the same as a CalWORKs case. Form MC 210 RV is not required until the annual Medi-Cal redetermination.

E. No *Ex Parte* Review and No AC 38 Conversion Required

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Workers are not required to conduct an *ex parte* review and shall not convert a person to AC 38 when the CalWORKs eligibility has closed for one of the following reasons:

- loss of California residency;
- the beneficiary submits a written request to discontinue Medi-Cal benefits;
- incarceration;
- death; or
- the individual is transitioning to another PA program that provides Medi-Cal (Foster Care, SSI, IHSS AAP, etc.).

The discontinuance reason which requires no further review of Medi-Cal eligibility must be included in the narrative and documented in the CalWORKs case record. If a discrepancy is discovered when reviewing the case record, the worker must follow-up and take appropriate action. For example, if the worker discovers that the case should have closed for other reasons that require an *ex parte* review, the worker shall complete the *ex parte* and determine if conversion to ongoing Medi-Cal is appropriate.

Note: Other family members discontinued from CalWORKs may be entitled to an *ex parte* review and conversion to AC 38 benefits. Therefore, each individual's reason for CalWORKs discontinuance must be reviewed.

F. AC 38 Process

When converting AC 38 cases to ongoing Medi-Cal, workers must first obtain any verification/information available that are essential to determining ongoing Medi-Cal eligibility from other PA case records (following *ex parte* guidelines outlined in MPG Article 4, Section 7, Item 10 and place copies in the Medi-Cal case record.

In any of the situations below that involve failure to provide verification, the worker must request the information using the procedures described in MPG Article 4, Section 7, Item 10, Example 2. AC 38 benefits are to be granted and an *ex parte* review completed in the situations described in items F.1 through F.5 below.

Do not request information or verification that:

- has been previously provided within the last twelve months;
- is not subject to change (i.e., identification, social security number, etc.);
- is available for verification by workers; or
- is not necessary for completing a Medi-Cal determination.

1) Failure to Complete the CalWORKs Annual Renewal

CalWORKs discontinuances due to failure to complete the annual renewal must have a Medi-Cal annual redetermination completed. This would also apply if the CalWORKs annual renewal were due while the AC 38 case is being processed. The MC 210 RV is to be used for the purpose of completing the annual redetermination. Discontinue the AC 38 benefits with timely notice if the beneficiary fails to complete the MC 210 RV within the required timeframe. If the redetermination is completed timely and Medi-Cal eligibility is established, certify the case for 12 months from the signature date on the MC 210 RV.

Note: When the MC 210 is used in the above situation, worker must obtain MC 13s and, if applicable, PWE status must be documented in the case file.

Children in the MFBU will not be eligible to the Continuous Eligibility for Children (CEC) Program if ineligibility to Medi-Cal is determined upon processing the annual redetermination. Since an annual redetermination is due, the children's 12 months of zero share of cost Medi-Cal would have expired.

MPG SNs 01-01 and 01-01 Add. A

2) Loss of Contact/Whereabouts Unknown

When a CalWORKs case is discontinued for loss of contact/whereabouts unknown, follow the procedures for requests for information outlined in MPG Article 4, Section 7, Item 10, Ex. 2. Send the request for verification to the last known address of the beneficiary and take the following action as appropriate:

- If return mail is received, discontinue the case.
- If partial information is received, send a notice to discontinue the parents and evaluate the children for CEC.

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- If all the requested information is received, evaluate the household members for continuing Medi-Cal.
- If the evaluation indicates ineligibility or SOC Medi-Cal, take appropriate action on the parents and evaluate the children for CEC.

3) Only Eligible Child Leaves the Home

Other family members must be evaluated for all other possible eligibility to Medi-Cal when the only eligible child leaves the home. Children removed from the home, as part of the Family Reunification (FR) Program, may not link FR parents to 1931(b) or Medically Needy Medi-Cal. See MPG Article 5, Section 4 for instructions on how to treat a person who alleges disability.

4) Failure to Provide Situations

Workers are to obtain information/verifications necessary for an accurate eligibility determination. Follow the instructions outlined in MPG Article 4, Section 7, Items 9 & 10. If a CalWORKs case closes for failure to provide, any children discontinued from the CalWORKs case under nineteen years of age may be eligible to the CEC Program.

5) Eighteen-year-old Completes School and is No Longer Eligible to CalWORKs

A child in this situation is entitled to AC 38 benefits and an *ex parte* review of the case record. The child must be evaluated for eligibility to continuing Medi-Cal. If eligibility to a zero SOC program cannot be established, the child must be evaluated for CEC, since the child is still under nineteen years of age.

G. AC 38 Negative Action Codes

AC 38 cases must be discontinued with one of the following negative action codes.

1) 001-Death.

2) 004-Use for failure to complete the statement of facts or provide requested verification. Note: Use the 915 discontinuance NOA with this negative action.

3) 035-Use this code when any Medi-Cal Program benefits are continued for at least one person on the case for any reason. No NOA is required when using this code for the persons whose Medi-Cal benefits are continued. MPG SN 00-01

4) 038-Use this code only when all persons on the case are determined ineligible for Medi-Cal only. This includes reasons such as no linkage or excess resources. This code is not to be used for failure to provide. ACLs 91-67 91-101

5) 048-Loss of residence.

6) 097-Discontinuance at beneficiary's request.

Do not use negative action codes 093, 099 or any other codes not listed above. Negative action codes not listed above are for regular Medi-Cal only and may not transmit an AC 38 termination to MEDS. ACWDL 01-36

7) 098-Whereabouts unknown. Will terminate Medi-Cal benefits.

5. CRAIG V BONTA ACWDL 03-24

Based on the 2003 Craig v Bonta (Craig) court order, new procedures are being established for continuing the Medi-Cal benefits for certain categories of SSI/SSP individuals discontinued from SSI effective 7/1/02. The Craig procedures replace the previous Ramos v Meyers procedures. As under Ramos v Meyers procedures, Mission Valley Family Resource Center (FRC) will process the majority of the Craig cases. Also, as under Ramos v Meyers procedures, Mission Valley FRC will continue to refer Long Term Care (LTC) and No Longer Disabled cases to the intake FRC responsible for the beneficiary's zip code for processing.

A. The following are changes as a result of Court's decision in the Craig lawsuit:

1) Beneficiaries discontinued from SSI no longer have to complete a statement of facts or request Medi-Cal to be evaluated for ongoing Medi-Cal benefits.

2) Craig cases are to undergo an evaluation following SB 87 guidelines. This includes beneficiaries who were discontinued from SSI due to loss of contact.

3) For Craig cases, information received over the phone can be used to establish ongoing eligibility. However, income and property must be verified in writing.

4) The following items are **not** needed to establish ongoing Medi-Cal eligibility for Craig beneficiaries:

a) MC210;
b) MC210RV;
c) SAWS 1;
d) MC13;
e) Verification of identity;
f) Verification of residency.

5) DHS will discontinue the monthly Ramos listing and add Craig beneficiaries to the monthly Exception Eligible report. Beneficiaries remain on this list until an eligibility determination is made and the information is reported to MEDS.

6) If a Craig individual is in LTC, the worker must call the facility and ask if the individual is competent. If the facility indicates that the individual is not competent, the worker must ask if he/she has someone to represent him/her. If the individual does not have a representative, either through the facility or through a relative, friend, etc., a referral to the Public Guardian must be made. ACWDL 03-25

7) A new abbreviated referral form 14-78 (Appendix B) has been developed to refer to the Public Guardian incompetent Craig individuals in LTC who do not have a representative. The completed 14-78 is to be sent to Craig Liaison at mail stop 0-95. ACWDL 03-25

B. How to Identify Craig v Bonta Beneficiaries ACWDL 03-24

DHS has created three new aid codes to identify Craig beneficiaries on MEDS.

CRAIG AID CODES

1E	Aged
2E	Blind
6E	Disabled

Additionally, MEDS shows the following information that can be used to identify Craig beneficiaries.

MEDS	**MEDS Screen**
Eligibility status code ending with **6**	INQM
Notice type **87**	INQB
Government responsibility code of **3**	INQM
Case number beginning with **9** followed by the beneficiary's SSN	INQM

C. How to Identify SSI Groups on Meds

Craig beneficiaries are in one of the following six groups. The Pickle Code on the MEDS INQM screen identifies these groups.

1) No Longer Disabled

DHS will continue to put the No Longer Disabled population in non-Craig aid code 6N for three months. If the beneficiary files an appeal, the person remains in aid code 6N throughout the appeal process. If the beneficiary loses his/her appeal or does not file the appeal within three months, MEDS will change the aid code to 6E. At that time, the beneficiary will appear on the monthly Exception Eligible report with an aid code of 6E, and workers must complete an SB 87 redetermination on the beneficiary. MEDS will use a Pickle Type "D" to identify this population.

2) Disabled Adult Child

DHS will place the Disabled Adult Child (DAC) in aid code 2E or 6E. MEDS will use a Pickle Type "T" to identify this population. For this group, workers are to review for DAC Program eligibility before reviewing for any other Medi-Cal program.

3) Disabled Widow(er)

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DHS will place the Disabled Widow(er) and surviving divorced spouse in aid code 6E. MEDS will use a new Pickle Type "W" to identify this population. For this group, workers are to review for Disabled Widow(er) eligibility before reviewing for any other Medi-Cal program.

4) Pickle

DHS will place the Pickle person in aid code 1E, 2E, or 6E. MEDS will continue to use Pickle Type "C" to identify this population. For this group, workers are to review for Pickle eligibility before reviewing for any other Medi-Cal program.

5) All Others Discontinued from SSI/SSP

DHS will place a person discontinued from SSI for any other reason in aid code 1E, 2E or 6E. MEDS will use a Pickle Type "X" to identify this population. This group does not require a disability evaluation. As true for all groups, do an SB 87 ex parte review to determine if there is ongoing eligibility.

6) Long Term Care

MEDS will use a new Pickle Status "L" to identify this population.

D. SB 87 Process for Craig Beneficiaries (See Appendix C for flow chart.)

The following are the steps workers must take, in the order listed, when they complete the SB 87 redetermination for Craig beneficiaries:

1) Send the beneficiary the following required forms: MC-219, MC-007, DHS 7007, and DHS 7077A.

2) Do an ex parte review using all sources of information available, including the MEDS INQX – SSI/SSP Information screen (Appendix B), IEVS, or county case (e.g. Medi-Cal, food stamps, GR, CMS, FC, etc.) currently active or active within the past 45 days.

3) If an eligibility determination cannot be made based on the ex parte review, attempt to contact the beneficiary by phone. The MEDS INQA – Address Information screen may show a phone number for the beneficiary. If it is not available on the INQA screen, or the number is incorrect, then use other county resources. If an eligibility determination can be made based on the ex parte review and information received in the phone call, do not send an AL 971.

4) If the ex parte review and attempted phone call do not provide enough information to make an eligibility determination, send the AL 971 requesting the missing information. Attempt a second phone contact.

5) Give the beneficiary 20 days to provide the requested information. ACWDL 03-24

6) If the beneficiary does not respond within 20 days, deny the case on CDS and send him/her a Medi-Cal discontinuance notice for the end of the month in which 10-day notice can be given and send 14-28 to the MEDS clerk to deny the County's SB 87 Medi-Cal determination which will discontinue the Craig case on MEDS (see Appendix D regarding completing 14-28).

7) If the beneficiary provides only partial verification, attempt to contact him/her by phone and in writing to request the missing verification. If the beneficiary does not provide within 10 days from the date of the second notice, deny the case on CDS and send discontinuance NOA (allowing for 10-day notice). Send a 14-28 to the MEDS clerk to deny the County's SB 87 Medi-Cal determination which will discontinue the Craig case on MEDS (see Appendix D regarding completing 14-28).

8) If the beneficiary returns all the information within 30 days after termination, determine eligibility as though he/she returned the information timely. If the beneficiary is eligible, grant the case on CDS. This will override MEDS with the appropriate approval code and end the Craig eligibility.

9) If the AL 971 returns in the mail as loss of contact because the Post Office could not deliver it to the intended person, had no forwarding address, or marked it undeliverable, deny the case on CDS and send a 14-28 to the MEDS clerk to deny the County's SB 87 Medi-Cal determination which will discontinue the Craig case on MEDS (see Appendix D regarding completing 14-28). Send a discontinuance NOA to last known address.

10) If SSA discontinued the beneficiary due to loss of contact, workers still need to follow the ex parte process. If the Post Office returns the AL 971 as undeliverable, deny the case on CDS, send a discontinuance notice, and submit a 14-28 to the MEDS clerk to deny the case on MEDS which will discontinue the case on MEDS (see Appendix D regarding completing 14-28).

E. Case/MEDS Actions

1) Approvals

If the Craig beneficiary is eligible to ongoing Medi-Cal benefits, grant the case using the appropriate aid code. The effective date will be the first of the future month. A 10-day notice must be given to discontinue Craig benefits. The effective date of the county case will be the first of the month following adequate 10-day notice. The granting action will override MEDS with the appropriate aid code. This ends Craig eligibility.

2) Denials

If the Craig beneficiary is not eligible to ongoing Medi-Cal benefits, workers must deny the case using the appropriate aid code. ACWDL 03-24

F. Redetermination Dates

Backlogged Craig cases (discontinued between June 2002 and June 2003) are to be given a redetermination date 12 months from the date the eligibility determination was made.

Craig cases discontinued after June 30, 2003 will be given a redetermination date 12 months from the date SSI discontinued.

If the Craig beneficiary is added to an already active Medi-Cal case for other family members, a priority line entry must be made in the case indicating the former Craig beneficiary's redetermination due date. If the case redetermination date for the family is prior to the former Craig family member, and the family does not submit a statement of facts, other family members are to be discontinued and the renewal date reset through the end of the former Craig beneficiary's certification period.

6. BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP) ACWDL 06-25

The California Department of Health Services (DHS) has the authority to complete eligibility determinations for BCCTP applicants under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and will be discontinued from her BCCTP eligibility, an SB 87 eligibility review must be completed before her BCCTP benefits can be discontinued. BCCTP does not have the authority to make determinations of eligibility for any other Medi-Cal program. Therefore, when BCCTP determines that a woman is no longer eligible for Medi-Cal under the federal BCCTP rules, the BCCTP staff will continue the BCCTP benefits until the worker completes the eligibility determination.

A. A woman can become ineligible for federal BCCTP Medi-Cal benefits when any of the following occurs:

1) She turns 65 years of age,

2) She has obtained creditable insurance coverage, as determined by BCCTP, or

a) A woman having the following types of coverage would be considered to have creditable coverage:
(1) A group health plan,
(2) Health insurance coverage – benefits consisting of medical care (provided through insurance, reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer,
(3) Medicare,
(4) Medi-Cal (full-scope, zero SOC),
(5) Armed Forces insurance, or
(6) A state health risk pool.

b) The following coverage is not considered to be creditable coverage:
   (1) Limited scope coverage, such as those that only cover dental, vision, or long-term care, or
   (2) Coverage is only for a specific disease or illness, not including breast or cervical cancer.

3) She no longer needs treatment for breast and/or cervical cancer, as determined by her treating physician.

Only those cases where the woman is determined by BCCTP staff to no longer meet the federal BCCTP eligibility criteria will be referred to the county. There are certain reasons for discontinuance from BCCTP Medi-Cal that do not require a redetermination. These exceptions are:

a) Death,
b) Moved out of state,
c) Voluntary withdrawal from the Medi-Cal program,
d) Failure to cooperate, or
e) Fraud.

B. When the BCCTP beneficiary is determined no longer eligible for federal BCCTP Medi-Cal, BCCTP staff will send a NOA to inform her of this, as well as the reason for the discontinuance. The NOA will advise the BCCTP beneficiary that she will continue to receive full-scope, no-cost Medi-Cal or restricted Medi-Cal on an interim basis until the county makes a determination of her eligibility for any other Medi-Cal program. The NOA also includes language to advise her that, during the county's redetermination, she will be asked by the county to provide additional information on income, resources and family composition.

C. During the County redetermination period, the beneficiary will continue to receive the same level of Medi-Cal benefits as she was receiving under BCCTP until an eligibility determination is reported to the Medi-Cal Eligibility Data System (MEDS).

D. BCCTP staff will notify the county BCCTP Liaison at Medi-Cal Program via secured e-mail when a BCCTP case requires a county redetermination under other Medi-Cal programs. If BCCTP staff has information that the beneficiary already has an open Medi-Cal case at the county, BCCTP staff will include the county case information on the Notification form with the county case number and worker code showing on MEDS to facilitate the county redetermination process as the worker may not be aware of the change in the BCCTP beneficiary's circumstances that generated the BCCTP discontinuance. BCCTP staff will send a copy of the case record by regular mail. The BCCTP case file may contain the following documents:

1) BCCTP County Notification-Medi-Cal Determination form (Appendix H),
2) BCCTP application (the screening and diagnosis to be blacked out),
3) BCCTP continuing Eligibility Redetermination form if an annual redetermination was completed,
4) BCCTP Rights and Responsibilities form,
5) Statement of Citizenship, Alienage, and Immigration Status (MC 13), if applicant did not declare she was born in the U.S. or U.S. territory,

6) Verification/documentation of immigration status,
7) Copy of Social Security card or other identification, if available,
8) Health Insurance Questionnaire (DHS 6155), and
9) BCCTP Medi-Cal NOA advising her of her discontinuance from federal BCCTP Medi-Cal.

E. In the future, DHS will establish three interim aid codes. Until these interim codes are operational, federal BCCTP beneficiaries will continue in the same BCCTP aid code, pending the outcome of the worker's eligibility determination. Workers will be notified when these interim codes become available and further instructions will be provided.

F. During the redetermination period, if the woman being discontinued from federal BCCTP Medi-Cal appears to be eligible for State-funded BCCTP coverage, BCCTP staff will concurrently determine her eligibility under the State-funded BCCTP pending the outcome of the worker's Medi-Cal eligibility review. This concurrent review will ensure that a determination will be made if she is eligible under the State-funded BCCTP so that she may continue to receive cancer treatment without any break in coverage, if she is not eligible under any other Medi-Cal program. If the worker determines that she is eligible for full-scope zero SOC Medi-Cal under another program, she will be terminated from BCCTP Medi-Cal coverage at the end of the month and will not be placed into State-funded BCCTP. If she is eligible for another Medi-Cal program, but with a limited scope of coverage or a SOC, she may be determined eligible for State-funded BCCTP if she meets all State-funded eligibility criteria.

G. BCCTP aid codes are the responsibility of DHS. BCCTP eligibility information is available in the MEDS secondary screens (Q1, Q2 or Q3). The BCCTP beneficiaries who will be discontinued from BCCTP benefits for the reasons identified above and who require a county Medi-Cal redetermination are in the three BCCTP aid codes, below.

0P – Federal BCCTP eligibility determined, full-scope, no-SOC Medi-Cal.
0U – Federal/State-funded – Restricted Medi-Cal services and State-funded cancer treatment and related services for women without Satisfactory Immigration Status (SIS) – redetermination does not include the State-funded services.
0V – Continuing Federal Restricted Services for those who were 0U eligibles, but have exhausted their period of State-funded cancer treatment services, but still need treatment and still meet all federal BCCTP requirements except for SIS.

H. When the worker receives a case for redetermination and the worker pends the case in CalWIN, CalWIN will transmit a transaction to report the date the county received the case and started the redetermination process. There will not be any special transaction entries required to change a BCCTP aid code to another Medi-Cal program aid code. If the beneficiary is found eligible for regular Medi-Cal, then the worker will report the eligibility via CalWIN as any other newly eligible beneficiary. If the beneficiary is ineligible for any Medi-Cal program, the worker will deny the case in CalWIN and a transaction will be transmitted to report the outcome to MEDS. The worker must issue a NOA to approve or deny regular Medi-Cal to the beneficiary.

I. The worker, upon receipt of a BCCTP case, must complete the eligibility review within 60 days. The 60-day period begins from the date BCCTP staff sends the BCCTP

Notification via facsimile. Unlike other Medi-Cal applicants, the BCCTP applicants do not complete a standard Medi-Cal Statement of Facts when they apply for Medi-Cal under BCCTP. The BCCTP applicants complete an abbreviated BCCTP Internet-based application and a modified BCCTP Rights and Responsibilities form at an enrolling provider's office. Because BCCTP has no income or resource requirement, and the beneficiary's household composition information is not obtained with the application, the beneficiary's BCCTP case file contains limited information that the worker can use to complete the eligibility review. Workers must use the SB 87 process to obtain any additional information required to make an eligibility determination for other Medi-Cal programs. There will be no MC 210 in the case file.

1) Worker must ensure that these beneficiaries receive copies of the forms in the standard Medi-Cal information notices, including the MC 007 (Medi-Cal General Property Limitations), MC 219 (Important Information for Persons Requesting Medi-Cal), DHS 7077 (Notice Regarding Standards for Medi-Cal Eligibility), and DHS 7077A (Notice Regarding Transfer of a Home for both a Married and an Unmarried Applicant/Beneficiary), so that they have necessary information about property and spenddown.

2) The worker must make additional contacts with the beneficiary to obtain information to complete the eligibility review. If workers have specific case questions or need additional information from BCCTP, they should contact the BCCTP Eligibility Specialist assigned to the case. The BCCTP Eligibility Specialist e-mail address and telephone number can be located on the BCCTP County Notification form. All BCCTP Medi-Cal cases referred to the worker for a Medi-Cal determination must be redetermined under the SB 87 three-step process. Workers must follow each step sequentially until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately determined as described in 5.D above.

J. All beneficiaries in the three federal BCCTP Medi-Cal aid codes have the same hearing and appeal rights as any other Medi-Cal beneficiary. If the woman files an appeal on the BCCTP Medi-Cal discontinuance, the BCCTP Eligibility Specialist will prepare the position statement. If she is denied Medi-Cal based on the worker's determination and she files an appeal, the County Appeals Representative will prepare the position statement.

K. If a former BCCTP beneficiary is being added to an existing Medi-Cal Family Budget Unit (MFBU), the Annual Redetermination date for this individual is the same redetermination date as the other members in the MFBU. For all other BCCTP women who are determined eligible for Medi-Cal, the Annual Redetermination date will be 12 months from the month the worker completes the redetermination under another Medi-Cal program. For example:
- BCCTP beneficiary placed in interim Medi-Cal aid codes: June 2007.
- Worker receives BCCTP case file and pends the case: June 2007.
- Worker approves no-cost Medi-Cal: August 2007.
- Next Annual Redetermination is due: July 2008.

L. The full-scope BCCTP Medi-Cal eligibles have voluntary enrollment in Managed Care.

CODES AND NOAS/ MEDS INQP SCREEN

APPEAL-DATE

This field will give the date an appeal was filed.

APPEAL-LEVEL

There are many codes that may appear in this field. The key codes that ETs need to be aware of are:

R	Reconsideration
H	Hearing
A	Appeals Council Review

NOTE: SSA updates appeals information on a recipient's SSI/SSP Medi-Cal record **only** if a change occurs. Because of this, some records on MEDS will reflect previously used Appeals Level Codes. This can be problematic since an "A" previously indicated a "First Level Appeal" and an "R" indicated the "Hearing Was Denied." The current codes were implemented October 23, 2000. If the Appeals-Date on the MEDS INQP screen is prior to that, the code used was a previous code.

DECISION CODES

The following codes indicate the decision rendered on the appeal:

AD	Dismissed/Abandoned
FA	Favorable/SSA Appeal
FC	Fully/Partially Favorable
FF	Fully Favorable
FN	Favorable/SSA Not Appealed (court case only)
OT	Closed: Other
PF	Partially Favorable
T1	Dismissed: Claimant Deceased
UA	Unfavorable/Appealed By Recipient (court case only)
UF	Unfavorable
UN	Unfavorable/Not Appealed By Recipient (court case only)
WC	Dismissed/Withdrawn (converted with record only)
WD	Dismissed: Withdrawn
1D	Dismissed: Cannot Be Appealed
2D	Dismissed: Filed By Improper Requestor
3D	Dismissed: Filed Late Without Good Cause
4D	Dismissed: Withdrawn

NOA-DATE

This field gives the date of the most recent NOA that was mailed to the former SSI recipient.

NOA-TYPE

This field gives the type of NOA that was sent to the former SSI recipient. The following codes will appear in this field:

22 DHS Notice Type 22. This notice informs the beneficiary that cash benefits were terminated, but Medi-Cal will continue while a "redetermination" is made. In order to be redetermined, the beneficiary must complete the enclosed forms.

23 DHS Notice Type 23. This notice informs the beneficiary that the SSI-based Medi-Cal will be discontinued because no forms were submitted to the county.

26 DHS Notice Type 26. This notice informs the beneficiary that if a timely SSI appeal is filed because they do not agree with SSA's decision that they are no longer disabled, Medi-Cal will continue through the SSA appeals process.

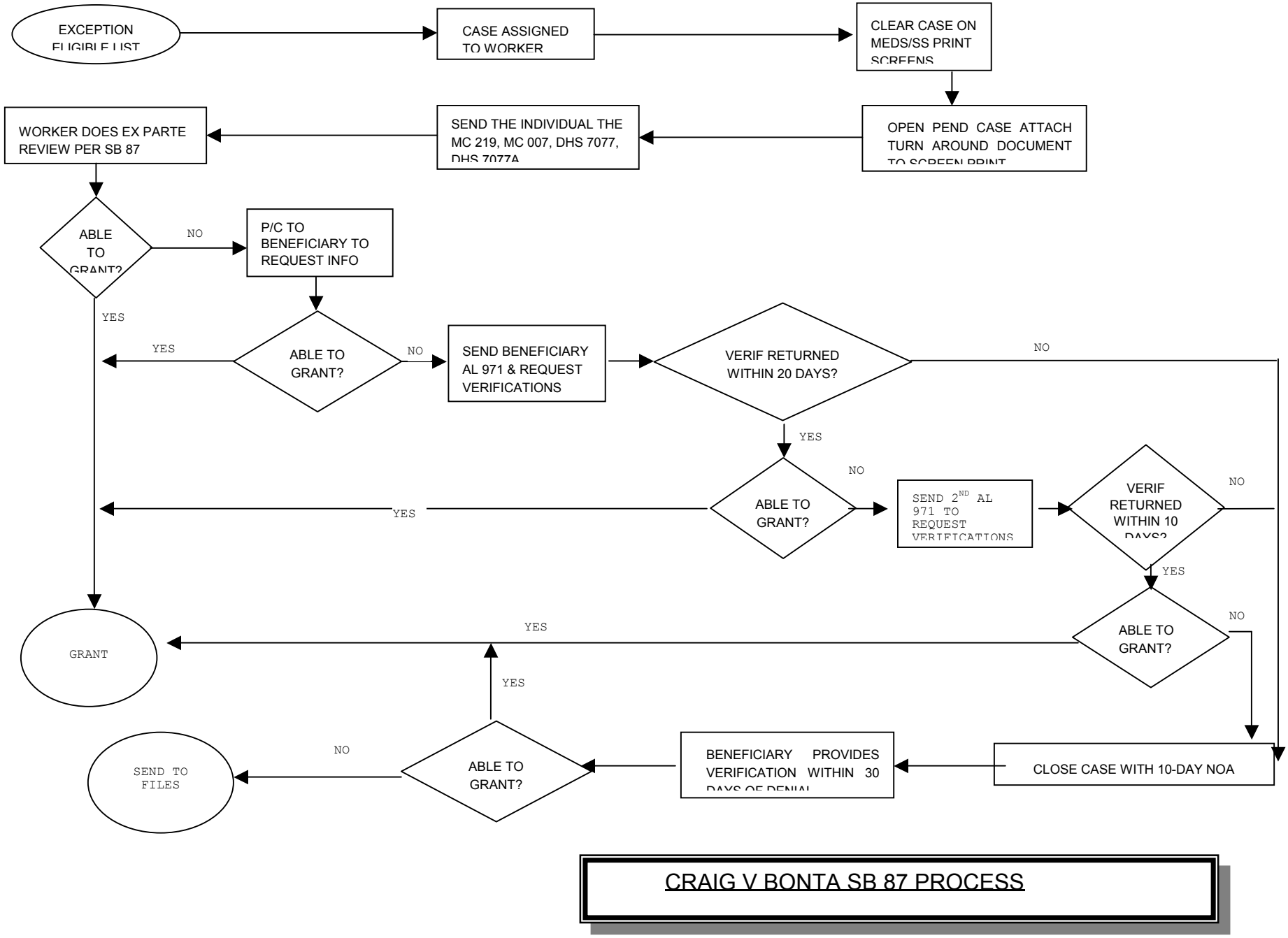
28 DHS Notice Type 28. This notice informs the beneficiary that the notice of the discontinuance of Medi-Cal benefits they received from the county should not have been sent and their Medi-Cal benefits will continue.

CO The beneficiary was sent a county generated NOA informing that his/her SSI-based Medi-Cal will be discontinued as a result of the "redetermination." No linkage could be established to continue Medi-Cal eligibility.

ND Loss of SSI disability status (no NOA issued). This code is posted at Ramos processing when DHS receives SDX information that a case is in no longer disabled status. This code will stay in the system until it is overlaid by another code such as 22 or 23.

Discontinued CalWORKs Reasons
Ex Parte/1931(b)/Aid Code 38
TABLE

REASON FOR CALWORKS DISCONTINUANCE	ELIGIBLE TO AUTOMATIC 1931(b) CONVERSION AFTER 38 PLACEMENT	EVALUATION FOR ALL MEDI-CAL PROGRAMS REQUIRED AFTER 38 PLACEMENT
Loss of California residency	No	No
Written request to discontinue CalWORKs and Medi-Cal	No	No
Incarceration	No	No
Death of beneficiary	No	No
Transition into another PA program that provides Medi-Cal benefits	No	No
Failure to cooperate with child/medical support requirements (applies to custodial parent or caretaker relative only and not children or pregnant women up to 60 days post partum)	No	No
Failure to provide monthly income report	Yes	No Unless worker later becomes aware of a change that affects 1931(b) eligibility.
Non-cooperation with Welfare-to-Work requirements	Yes	No
Expiration of CalWORKs time limits	Yes	No
Failure to complete the CalWORKs annual redetermination	No	Yes
Loss of contact/whereabouts unknown	No	Yes
Only eligible child leaves home	No	Yes Evaluate for pending disability, if alleged.
Change in household composition that has resulted in non-cooperation with the evidence gathering requirements for the AU	No	Yes
Change in household circumstances that affect Medi-Cal eligibility	No	Yes
Resources exceeds limits	No	Yes Potential FPL
Income exceeds standards	No	Yes
18 year old turns 19	No	Yes Potential CEC
CalWORKs parent(s) is transferred to the Family Reunification Program after children are removed from the home.	No	Yes



CRAIG V BONTA SB 87 PROCESS

CRAIG v BONTA AUTOMATION

ET ACTION:

- Review file clearance information on MEDS/SCI
  - Craig aid codes are 1E, 2E, or 6E
  - Craig county ID will be 37-1E-9 (10 digit CIN#) etc.
  - Verify correct CIN#

- Follow normal Medi-Cal application processing procedures as if processing a new application.

- The client will not have dual eligibility under both the Craig v Bonta aid code and another Medi-Cal program aid code so granting actions must be taken effective the first of the future month. (Granting actions taken by the county before **or after** MEDS renewal will cause MEDS to automatically terminate the Craig record at the end of current month and record ongoing eligibility effective the first of the future month forward under the County ID.????)

- If denying the application, worker must submit a 14-28 HHSA MEDS Network On-Line Request form to MEDS Operator with the following information:

  - 14 digit county ID (county code of 37-aid code of IE- 7 digit county case serial number-last digit of FBU-person number)
  - birth date (same as Craig record on MEDS)
  - MEDS ID (SSN or pseudo – same as Craig record on MEDS)
  - CIN#
  - Application date (date county began SB87 determination/county application date from LMO)
  - Application flag (valid county value is P)
  - Denial date
  - Denial reason (see attachment to MPG Letter # 529 or MEDS Quick Reference Guide)

Although we are denying a Medi-Cal application, workers will send a NOA to notify the client that temporary Craig v Bonta benefits have **discontinued**, or that temporary Craig v Bonta benefits have discontinued and ongoing eligibility has been established under another Medi-Cal program.

MEDS will produce monthly (Renewal) Exception Eligible Reports to reflect the number of months a “Craig v Bonta” beneficiary has remained in aid code 1E, 2E, or 6E.

MED OPERATOR ACTION

MEDS Operator will process the 14-28 and submit the AP18 on-line transaction to report the denial with the information listed above from the ET.

Automation Grid for CalWORKs Conversions to Edwards

Below is an automation grid for discontinued CalWORKs cases that convert to an Edwards (aid code 38) case and then transfer into a 1931(b) case.

Close the aid code 38 case with a negative action of 35 effective the end of the current month. Open a 1931b case using an AA (AB or AC as appropriate) FBU and the following automation entries:

ELIG Screen	
Aid Type	M3-1
Aid Change Date	Month following CW discontinuance
RV Due Date	Same as closed CW
Positive Action "Transfer" Code	404
Positive Date	1st of month following CW discontinuance
PDT1 Screen	
Positive Action Code	404
Positive Action Date	1st of month following CW discontinuance
PC Code	A or C
PC Effective Date	1st of month following CW discontinuance
MC/Aid	3N-0

DISCONTINUED IHSS RESIDUAL CASE AUTOMATION

WORKER ACTION

- Review the file clearance information on MEDS/SCI.
    - Discontinued IHSS Residual Cases convert from 18, 28, and 68 to 14, 24, or 64 aid codes on MEDS.
- Workers must match MEDS when open pending the application on BDLM.
- Follow SB 87 Medi-Cal determination processing guidelines.
- Granting actions must be taken effective the first of the future month. (Granting actions taken by the county before MEDS renewal will post ongoing eligibility effective the first of the future month forward. Granting actions taken by the county after MEDS renewal should have an effective date of the first of the future month.)
- If the application is denied, the worker must submit a 14-28 HHSA MEDS Network On-Line Request form to the MEDS Operator with the following information:
    - 14 digit county ID (county code of 37-aid code - 7 digit county case serial number-last digit of FBU-person number)
    - Birth date (same as existing record on MEDS)
    - MEDS ID (SSN or pseudo – same as existing record on MEDS)
    - CIN #
    - Application date (date county began SB 87 determination/county application date from LMO)
    - Application flag (valid county value is P)
    - Denial date
    - Denial reason (see attachment to MPG Letter # 529 or MEDS Quick Reference Guide).
- If the application is denied, **NOA 943 must be sent out** informing the beneficiary that the temporary benefits from the discontinued IHSS Residual case will be discontinued, with the date of discontinuance written on the notice. A separate denial notice must also be sent out for denials other than failure to provide necessary information.
- If the application is approved, a granting notice must be sent out informing the beneficiary that eligibility has been established under another Medi-Cal Program.
- If the discontinued IHSS Residual recipient has moved to another county, an ICT must be processed and online transaction needs to be submitted to update MEDS with the current residence address and residence county.

MEDS OPERATOR ACTION

MEDS Operator will process the 14-28 and submit the AP18 on-line transaction to report the denial with the information listed above from the worker or submit the EW12/EW55 transaction to report current residence address and residence county.

APPENDIX G

CRAIG v. BONTA QUESTIONS AND ANSWERS

ACWDL 04-31

QUESTION 1:

Workers were instructed (in MPG Special Notice 01-12, issued July 26, 2001) to evaluate the beneficiary for his/her continued eligibility under various avenues of eligibility, including the allegation of disability. If the Social Security Administration (SSA) discontinuance reason is "no longer disabled," can the beneficiary still use a disability allegation to obtain Medi-Cal eligibility?

ANSWER 1:

Yes, but only if the person alleges to have a disability different from the disability under which the SSI/SSP was granted. A recipient may be referred to State Programs-Disability and Adult Programs Division (SP-DAPD) if they had a previous disability, are discontinued from Medi-Cal for a reason other than their alleged disability (such as income) and are reapplying for Medi-Cal based on the allegation the disability continues to exist.

QUESTION 2:

Upon completing the SB 87 Redetermination, the worker finds that the beneficiary continues to remain eligible for full-scope coverage, but under another Medi-Cal program. Is the worker required to send a notice of action?

ANSWER 2:

Yes. Workers are required to notify beneficiaries in writing of their Medi-Cal eligibility or ineligibility, and of any changes made in their eligibility status or SOC.

QUESTION 3:

Are Craig beneficiaries dual-aid type eligibles? For example, if the worker receives an application April 15, 2006, and determines eligibility on May 28, 2006, does the worker grant eligibility back to the date the application was received or does the worker grant eligibility on July 1, 2006, after the June 2006 Medi-Cal Eligibility Data System (MEDS) renewal process?

ANSWER 3:

Craig beneficiaries are not dual-aid type eligibles nor can the worker require a Craig eligible person to complete an application for Medi-Cal benefits. If, however, the application is voluntarily mailed or given to the worker before an SB 87 Redetermination is processed, it can be used to complete the SB 87 Redetermination. However, continuous eligibility in the State assigned Craig aid codes on MEDS remains until the worker redetermines the eligibility and submits a transaction to MEDS. The ongoing eligibility information is only applied to the MEDS pending month of eligibility.

QUESTION 4:

When the worker sends a MEDS transaction to discontinue Craig eligibility due to Medi-Cal eligibility or ineligibility well in advance of the MEDS renewal date, we are finding that some of these cases are not being discontinued on the date we expect them to be discontinued.

ANSWER 4:

The MEDS logic was designed to use the denial date in the transaction to determine the discontinuance date. The worker must enter the denial date, not the date that they want the Craig eligibility to discontinue.

QUESTION 5:

After conducting an SB 87 Redetermination, it is determined that the beneficiary is eligible to Medi-Cal and that they are part of an existing Medi-Cal Family Budget Unit (MFBU). Do we align the Craig individual's SB 87 redetermination date to the family's annual redetermination date or do we realign the MFBU to the SB 87 Redetermination date?

ANSWER 5:

If a Craig individual is being added to an existing MFBU, realign his/her annual redetermination date so that it is the same annual redetermination date as the other family members in the MFBU. If, however, under the continuous eligibility for children (CEC) provisions, the Craig individual happens to be a child under the age of 19, the worker must determine if the child's eligibility goes beyond the family's annual redetermination date.

QUESTION 6:

When the worker contacts the client and provides the correct forms for the Medi-Cal determination, do we apply a SOC to the current month or the following month?

ANSWER 6:

Regulations require any negative action (including increasing the SOC) to be applied after a ten-day notice of adverse action has been mailed.

APPENDIX H

BREAST AND CERVICAL CANCER TREATMENT PROGRAM
COUNTY NOTIFICATION-MEDI-CAL DETERMINATION

Instructions: Complete each space or box. If information does not pertain to this case, indicate with N/A.

To:	**From:**
County:_____	State Department of Health Services
Medi-Cal Liaison Name:_____	Breast and Cervical Cancer Treatment Program
Liaison Telephone:_____	Eligibility Specialist (ES):_____
Fax Number:_____	ES Telephone:_____
E-mail Address:_____	ES Fax Number:_____
	ES E-mail Address:_____

BCCTP Beneficiary Information

Name		Phone number ( )	Alternate/Message phone number ( )
Address (number, street)		City	ZIP code
Authorized representative ☐ Yes ☐ No	AR name	AR phone number ( )	Beneficiary's primary language

Case Documents in Referral Packet:

- ☐ BCCTP Application or BCCTP Addendum Application for Signature
- ☐ Statement of Citizenship, Alienage, and Immigration Status (MC13)
- ☐ Medi-Cal Rights, Responsibilities and Declarations (MC210BC)
- ☐ Identifications
- ☐ Social security card
- ☐ Immigration documents
- ☐ Other Health Coverage Information (DHS 6155)
- ☐ Last Notice of Action
- ☐ Case details
- ☐ Other_____.

Reason for Federal BCCTP discontinuance:

- ☐ Beneficiary has turned 65 years of age on_____
- ☐ Beneficiary has obtained creditable insurance coverage_____
- ☐ Beneficiary no longer needs treatment for breast and/or cervical cancer_____
- ☐ Other_____

BCCTP COUNTY TRANSMITTAL 07/06